CHILDREN'S MEDICAL REPORT

Name of Child _____ Birthdate _____-_____-_____

Name of Parent or Guardian _____

Address of Parent of Guardian _____

A. **Medical History** (may be completed by parent)

1. Is child allergic to anything? No____ Yes____ If yes, what? _____

   _____

2. Is child currently under a doctor's care? No____ Yes____ If yes, for what reason? _____

   _____

3. Is the child on any continuous medication? No____ Yes____ If yes, what? _____

   _____

4. Any previous hospitalizations or operations? No____ Yes____ If yes, when and for what? _____

   _____

5. Any history of significant previous diseases or recurrent illness? No____ Yes____; diabetes? No____ Yes____; convulsions? No____ Yes____; heart trouble? No____ Yes____; If others, what/when? _____

   _____

_

6. Does the child have any physical disabilities? No____ Yes____ If yes, please describe: _____

   _____

7. Does the child have any mental disabilities? No____ Yes____ If yes, please describe: _____

   _____

Signature of Parent or Guardian _____

B. **Physical Examination:** This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N.C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

Height _____% Weight _____% Head _____ Eyes _____ Nose _____

Teeth _____ Throat _____ Neck _____ Heart _____ Chest _____

Abd/GU _____ Ext _____ Neurological System _____ Skin _____

Results of Tuberculin Test, if given: Type _____ date _____ Normal _____ Abnormal _____

Should activities be limited? No____ Yes____ If yes, explain:

Any other recommendations: _____

_____

_

Date of Examination: _____-_____-_____

Signature of authorized examiner _____ Office address (may be stamped)

Title _____ Phone # _____

(Continued on back or next page)